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CHILDREN ON THE NEW FRONTIER

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An examination of some current controversial proposals—and a new approach.

FRESH breezes from the Potomac invigorate most exponents of strengthened health and welfare programs but, oddly enough, seem damp and cold to many whose special interest is the welfare of children. Developments to which Joseph H. Reid, executive director of the Child Welfare League of America, alluded in the March issue of CHILD WELFARE lead to the dismal conclusion that 1962, which was to see a forward-looking celebration of the Golden Anniversary of the Children's Bureau, may well see a backward-looking commemoration of its demise.

The proposals which might lead to this event are neither new nor novel, but have received fresh and important support in a task force report prepared for President Kennedy.[1] The task force chairman, Wilbur Cohen, a distinguished social worker and a leading authority on public welfare and social insurance, is now Assistant Secretary for Legislation in the U.S. Department of Health, Education and Welfare. He was aided in the preparation of this report by Elizabeth Wickenden, now acting director of the Project of Public Services for Families and Children. The project, supported by the Field Foundation and conducted under the aegis of the New York School of Social Work, has an eminent advisory council whose names are well known to all concerned with social welfare. Miss Wickenden herself is an expert on social policy concerning public welfare. She has long been in the forefront of those working for better services. The preliminary documents prepared by the project echo and elaborate certain of the points contained in the task force report. Being preliminary, these materials cannot properly be said to represent the firm opinion of those associated with the project, as they are intended to promote discussion. Nevertheless, supporters of the Children's Bureau hear in the words of these documents the quietus of the Bureau.

Yet, why the lamentation? Sentiment is hardly a justification for the maintenance of what is after all merely a bit of governmental structure. Although sentiment *is* part of the picture, it is by no means all. Those who are reluctant to part with the Bureau are aware that here is a unit of the Federal government that enjoys the support and affection of millions of ordinary citizens. This support is manifest in the manner in which multitudes of civic organizations can be rallied to action on behalf of the Bureau. *Infant Care* alone, the nation's best seller, has brought the Bureau the affection of countless parents, and through them the attention of Federal legislators who view this pamphlet as a sure and certain means of winning friends who are also voters. With proper leadership the Bureau can command the concern of high-placed government officials in a manner unknown to other governmental units.

The Bureau has not gained this position through the gimmicks of public relations. Its status and prestige have been bought and paid for by the life energy of its renowned chiefs, whose listed names are a roster of America's great social pioneers. From the Sheppard-Towner Act through the recent expansion of the child welfare program, the Bureau has been an innovater and a pioneer. It has attracted to its staff an extraordinary group of creative and dedicated persons. In the Bureau particularly we see a coming-together on equal footing of health and welfare. The cliché of the whole child comes within hailing distance of actuality. Is all this to be dismembered?

A glorious past is not an argument for a future in perpetuity. Yet any corporation executive will testify that the intangible assets of goodwill are difficult to price but truly priceless. Before these assets are sacrificed in the interest of reorganization, partisans of children will want to know what is being bought, at what cost.

The relevant proposals that are gaining currency see the Maternal and Child Health and Crippled Children's programs as finding

* The NASW has not yet formulated its position on the issues discussed in this article. The writer, therefore, wishes to make it clear that he is presenting his own views and not those of the organization.

1 Report of the Task Force on Health and Social Security, Jan. 1961.

a home in the U. S. Public Health Service. The Child Welfare Services grants are placed with the Bureau of Public Assistance, which becomes a "Bureau of Family and Children's Service." This revitalized bureau then gives grants to the states for a genuine preventive and rehabilitative family service program. The Children's Bureau has long been stifled in its development by being a subordinate unit of a Social Security Administration which is primarily concerned with the enormous task of administering the great social insurance and the public assistance programs. Under the proposed plan, the Bureau is at long last freed from bondage. It is raised to its proper position close to the Secretary of the Department of Health, Education and Welfare—but it is a poor ghost of its former self.

It has lost its roots in local communities, since the grant programs have been severed. With these roots go appropriations, staff, community and Congressional support. With these roots go the rich yield of Children's Bureau research related to its own program. Indeed, with the development of a projected national institute concerned with research in family life, there is little research function remaining for the Bureau. Left with a nebulous advisory function, it is vulnerable to each new economy drive. The swift *coup de grâce* of abolition today would be kinder and clearer.

Of major concern, however, is not merely the existence of the Bureau but the attainment of objectives sought by all persons of good will—including those concerned with the task force, the project, the Children's Bureau and the Bureau of Public Assistance. Chief among these objectives is service for children in families receiving public assistance, particularly those in the Aid to Dependent Children program. The number of children in these programs is great—far greater than those in Child Welfare Services. Effective service would not only restore many families to independence, but would enable the program to come to grips with the complex of problems known to afflict many of these families.

Allied to this objective is the goal of reducing the proliferation of programs under varied auspices which constitutes an obstacle to family rehabilitation and a giant-size administrative headache. Most state officials will testify to the time and energy consumed by the effort to deal with the multitude of Federal grant-in-aid programs, each with its own peculiarities. The administrative separation on a Federal level leads to separations on a state level. While the projected reorganization would not solve the over-all problem it would, at least, bring two intimately related programs (child welfare and ADC) under one auspice.

Even more important, these proposals might to some extent reduce the army of social workers who converge on a single family. Social services are, alas, more allied to agency need than to family need. Thus a family that is truly beset by problems may be subject to the helping efforts of some half dozen social workers, when often their prime need is one key helping person. The proposals would, at least, make some small dent in that problem.

Those who oppose the changes proposed to achieve these objectives do so because they are convinced that the changes will not have the results anticipated, or because they believe the losses will counterbalance the gains. The number of children served by the public child welfare services is comparatively small. Program standards are high. The vast number of children in ADC families combined with the prevailing public attitudes toward family units on public assistance have made it impossible, in many instances, to make ADC a genuine service program. Combination of ADC with Child Welfare Services might raise ADC standards—or, it is important to add, might radically lower standards of public child welfare services.

Only 19 percent of the children receiving public child welfare services are in public assistance families.[2] In the majority of instances, therefore, combination at a Federal level would not affect the multiplicity of workers per family at a local level. If the child welfare workers were drawn into the very necessary task of service to ADC families, one must wonder who is to give service to the non-ADC children now receiving care?

The Children's Bureau has a special unit concerned with juvenile delinquency and good prospects for a delinquency grant-in-aid program. With the opposition of many child welfare authorities, the Bureau has kept services for delinquents out of the general child

2 Helen R. Jeter, *Children Who Receive Services from Public Child Welfare Agencies;* U. S. Department of Health, Education and Welfare, Children's Bureau Publ. 387, 1960, Washington, D.C., page 24.

welfare program. This has been done because of the recognition that funds and services to rehabilitate delinquents cannot and will not, in most states, flow through the child welfare and public welfare apparatus. These funds and services must reach courts, police, detention centers and training schools. In most states, welfare leadership is neither strategically, tempermentally nor professionally equipped to tackle the problem of delinquency control. The arguments against assigning this task to public child welfare services are strengthened when applied to a general family welfare program. Under the plan proposed, what becomes of the program to combat delinquency?

Added to these concerns is the reluctance to abandon the Children's Bureau and to separate children's health and welfare programs at a time when they should be better integrated —not disintegrated. All in all, a formidable case against the proposed changes—and even more formidable when the basic direction of the public assistance program is examined.

The festering sore at the heart of public assistance is the means test. Regardless of how it is viewed by social workers, the means test is seen by the public and their elected officials as a gate through which only the "worthy poor" are to be admitted. There is an assumption that all who cannot earn their own living are "unworthy." From this comes the ever-stiffening eligibility requirements that often make it impossible for the public assistance worker to aid the client. He is too busy looking for concealed assets. From the assumption of "unworthiness" comes the night raids, the newspaper blasts, and the generally negative attitude toward the assistance recipient. So pervasive is this attitude that even social workers have been heard to talk about "the right to assistance" on one hand, and day care as a means of "getting people off relief" on the other, as if "getting off relief" was the highest value.

The proposed reorganization at the Federal level does nothing to tackle this basic problem. It aggravates it. It further confuses the right to bread with a rehabilitation and treatment program. It approaches the public agitation over the unwed mother on ADC not by clearly and simply proclaiming the right to eat regardless of personal morals. Instead it beclouds that right by implying that in addition to money there must be the social worker who will treat the girl—meaning help her to conform to social expectations. These are two separate goals and their intermixture obscures the issue.

An understanding of the source of the opprobrium that attaches to means test programs makes it clear that the addition of the service component will not alter the attitude. Grants will continue to be a humiliating pittance. Eligibility requirements will grow. Nonconformists will be persecuted—partly by the public from whom the nonconformist extracts a tax, and partly by well-meaning but poorly equipped assistance workers who may inadvertently make conformity the payment for the assistance grant.

The radical but indicated cure is the abolition of the means test. This can be done by expansion of the social insurances, including the development of a family allowance plan. Through such a program, those in need will receive economic sustenance as a matter of right. Socially devalued (nonconformist) behavior can be tackled through related but different programs. The goal sought should not therefore be the expansion of the public assistance programs, but their reduction to the irreducible minimum.

The mere definition of long-term objectives for public assistance does not, of course, ease the plight of today's assistance client. Nor does the definition of objections to the task force type of proposal bring us closer to mutual objectives. Surely there is a place in the new frontier for genuine development of family and children's programs. Professional health and welfare workers and interested citizens need to find that place, but they probably will have to look at problems more basic than those which have to do with shifting a few small Federal programs around on the organizational chart.

Any plan to attain the objectives sought must rest on a conception of man which grants him maximum freedom to define his own self in an environment conducive to creative growth. It must grow out of social, biological, and psychological theory. The fatal flaw in the proposal examined is the implicit assumption that the behavioral problems of assistance clients will be solved or mitigated if only each family might have a fully qualified caseworker as their helping agent.

To grasp the poverty of such an assumption, one has only to consider the nature of such problems as delinquency, marital failure, child neglect, chronic illness, and unwed parenthood as they are manifest in today's families. These problems have physical, psychological, and social dimensions. They cannot be tackled by medicine, public health, psychiatry, or social work alone. They cannot be tackled solely on an individual, or a family, or a community basis. They will only yield to a program which takes full account of the interaction between psyche and soma; individual and group, including the family as a group; and group and community. Social policy must arise out of clearly articulated knowledge and values.

A program for the new frontier which meets this test might well differentiate between urban and rural communities. Today's rapidly deteriorating inner city, with its ever expanding suburban and exurban belts, requires a program which views man *in situ*. Such a program might well be geared on a Federal level to a "people-oriented" urban redevelopment. The Federal agency administering this plan would, of necessity, be interdisciplinary. Funds and technical aid could flow directly to urban development boards which would also, of necessity, be interdisciplinary. These urban redevelopment boards would receive grants for altering the face of the city so as to conserve human values, and only incidentally, real estate values.

A major portion of this program would involve the development of neighborhood service units by local agencies. Personnel would include social workers skilled in community organization who would work with citizens block by block to enable their participation in evolving and implementing the over-all plan, and keeping it up to date. Because persons beset by social, psychological, and health problems cannot fully participate in the democratic effort, neighborhood units would also have treatment facilities staffed by social workers skilled in casework and group work method, as well as by public health personnel.

Community involvement and treatment would look to the management of the social problems that confront us today. Equal emphasis would be given to a program looking to the future and designed to maximize opportunity. This program would flow through the urban development board to local units, and to a large extent be rooted in the school program and addressed to children and youth. Opportunities would be offered for the full development of scientific, artistic, or vocational skills. Involved in such a program would be funds and services for preventive medicine, group play, vocational opportunities, and scholarship incentives. The disciplines involved would be health, education, social work and psychology.

Physically, the neighborhood units might well be expanded settlement houses or neighborhood centers built to offer combined health, welfare and community service. Adjacent to school facilities and sharing many services in common, these centers would be designed for pleasure and comfort—the heart of a force for reinvigorating city life. People would come to the center to seek help and also to seek pleasure. Public assistance, social insurance, and child placement services would be a part of the center. Probation officers would also have quarters there.

The centers would be responsible to the urban development board, which would have a democratic base through the neighborhood unit councils. The board would also have clear authority, and while voluntary agencies could participate, the program would not be tailored to fit the status quo. Voluntary agencies which did not wish to tailor their programs to fit into a plan to manage and control social problems and maximize opportunities would of course be encouraged to develop as they wished, but without public funds. The urban development board would bring together city planning, health, welfare, education and correction. The Federal grants would, in essence, be funds now labeled public assistance, child welfare, urban redevelopment, and certain health and education grants.

In rural areas the program would feed into the consolidated school. Here the basic goals would be the same, but the apparatus less elaborate. The personnel employed would be more generalists than specialists. Relationships with urban centers would be developed for those requiring specialized facilities and services not available locally. The school units would be responsible to a state agency which would receive the integrated grant. The extension services now offered through the U. S.

Department of Agriculture and the land-grant colleges might be incorporated in the plan.

Federally, the program might be lodged in the Department of Health, Education and Welfare through an "Office of Urban and Rural Development." In that office might be placed certain key units concerned with the program, but not all such units. There might, for example, be a unit concerned with physical planning, the Office of Education, the Children's Bureau, the "Bureau of Family Assistance" (which would incorporate public assistance), and a newly created "Youth Conservation Bureau."

Since the shortage of professional manpower would block any such program, proponents would at an early date have to advocate a change in present patchwork methods of dealing with personnel supply. They cannot continue to support or advocate spotty Federal legislation which provides a trickle of social workers for mental health services here, a dribble of workers for child welfare there, and a drop of workers for schools over here—with similar approaches to other professions. Instead they would need to advance an overall national approach to the problem of the manpower shortage in health, education and welfare. Needed legislation would include aid for graduate schools and auxiliary teaching institutions, scholarships, funds for recruitment of personnel, and a research program concerned with personnel utilization and curriculum building.

Obviously, the complete plan as presented embodies enormous complexities. It is quite possible that it is completely unworkable and that a very different approach is needed. The plan presented is of value, however, if only as an illustration of the scope of thinking necessary to produce a real answer to the social problems which press for solution.

Those who find the proposals in documents issued by the Task Force on Health and Social Security and Project of Public Services for Families and Children unworkable or destructive need not present an alternative. Change for the sake of change needs no encouragement. Not every problem is capable of solution at a given point in time. Those critics, however, who agree with the task force and project objectives and who see the present programs as woefully inadequate do, at least, have a responsibility to work toward improvement.

The Golden Anniversary of the Children's Bureau offers that opportunity. If ill-considered change can be staved off, there might be an anniversary celebration that would draw refreshment and inspiration from the achievements of the past, but would focus on the future. With clarity concerning what it is we want to do about today's social problems and knowledge of their nature, the interest, intelligence, and creativeness of partisans of children can be harnessed at a local, state, and national level so that a workable plan can be created. The very drafting of such a plan will provide support for its enactment. It needs to be a sound plan, a big plan, a plan to capture the imagination. New frontiers are for children, too; but those of us who are particularly concerned must help to find the place.

EDITOR'S NOTE: *We urge readers to submit their views on this subject for publication. We want opinions; we want the pros and the cons; we want alternate proposals. In a word —we want discussion.*

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CAN LONG-TIME FOSTER CARE BE UNFROZEN?

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In this article we are challenged to examine some of our long established beliefs about foster care.

Is it true that social workers are turning against long-time foster care as a way of providing substitute family life for children who are "orphans of the living"? Professional discussion, the literature and research efforts in the field of child welfare reveal a growing and increasingly urgent concern for those children who are and will be cared for by foster parents for significantly long periods of time during their growing years. Whereas twenty-five years ago emphasis was upon "emptying the institutions" and increasing foster home care, today feeling is strong that for many children long-time foster care spells "doom" and produces irreversible damage. The field is concerned about the effects upon children of the extent and duration of deprivation prior to and during placement, the number of moves from foster home to foster home, the relationship or lack of it of natural parents to children in long-time care and the many other experiences which deeply influence the development of growing children.

Perhaps because social work has been, from its inception, an action-minded profession as well as one engaged in understanding the feelings and behavior of human beings, action of some kind comes to mind readily as a way of changing social environment. Hence panaceas appear cyclically in the professional literature. Today there is pressure among professionals to solve the dismal foster care picture by increasing adoption placements of children needing permanent families. Also, although the illusion is diminishing to some extent, there still appears frequently enough a belief that if sound casework service is available to placed children, to their foster parents and to their natural parents, reunion of children with their natural parents will more likely than not come about. Apparently it is hoped that through these emphases, long-time foster care will greatly diminish.

Ideals and Professional Goals

No one will deny that for a socially based profession, action to improve society and its methods of handling human life is an essential ingredient. Likewise a profession which sees daily the hurt and misery of children can be forgiven the human desire to find a panacea, and to find it at once. However, ours is not only a social profession but also a therapeutic one which understands and uses psychological knowledge and insight in helping people. Such understanding should provide self-enlightenment to deal with the inevitable "rescue fantasies" of professionals in the child welfare field. The problem is not in having rescue fantasies but in knowing the difference between them and carefully thought out professional goals and practices.

The social work profession in this country is subject to an interesting, complex and difficult conflict. On the one hand, it stands for and wants to help bring about the kind of society spelled out in democratic ideals. On the other hand, it must, to be helpful, understand each person for what he is, must know his strengths, his weaknesses; in short, must understand him and his individual problems as differentiated from others even though the problem itself will not be unique among human beings. Additionally, social work, to be helpful, must understand the individual in his interaction with others and in his social frame of reference.

In child welfare, ideals have often been confused with achievable goals and possibilities in practice at a given time. Unawareness of this confusion has frequently resulted in professional frustrations as well as misunderstanding by the lay community which supports social services.

The ideal that every child have a permanent, loving family of his own has led us often to prescribe adoption, for example, as the optimum solution for all children without families of their own. It has been stated frequently that any child is adoptable if there is a family ready to adopt him. Do we mean this? Is the most important criterion that someone wants him? Are there not other considerations? Children beyond babyhood may have

sibling connections, may have developed serious problems of one kind or another, may be unable to respond to the expectations of an adopted family. Families wishing to adopt older children, disturbed children, ill children not infrequently have emotional problems of their own. While the field of adoption has expanded in healthy ways, particularly since World War II, there has not as yet been enough research into practice to show the pitfalls and to guide us toward better methods of facilitating adoptions of older children, troubled children and children of mixed racial heritage.

The Need for Study of Practice

If, as professionals, we deplore the evils of long-time foster care as now provided, rather than seeking a panacea we must study practice to see who the children are who need this kind of care, who their families are, what kind of substitute homes have been provided, what kind of professional mistakes have been made, and how practice can be improved. Professionals should give serious thought to their part in condoning cheap care. While it is a well-recognized fact that children requiring foster home care today are beset by serious problems needing special parental handling, how many foster parents are carefully selected and adequately paid for this delicate job? What educational opportunities are there for foster parents faced with daily childhood problems of far greater than average severity? Have we documented well enough the necessity of carefully and appropriately selected foster homes to meet the needs of a variety of children? Have professionals been responsible for the failure to differentiate children sufficiently in order to know what each child needs for corrective and ultimately healthy living? Have we held to the conviction that basic to sound foster care is the therapeutic skill of the caseworker in studying and developing foster homes, in working with children, their families and foster parents?

In an attempt to explore these and other questions, the Children's Aid Society has, during the past several years, used a number of methods of reviewing its practice. Small research projects of various kinds have been slowly building observations and questions about what happens to children in long-time care. In addition to the more formal research projects, a significant number of records have been read and analyzed from a purely casework point of view. Some of the ideas evolving out of these investigations have been presented to and discussed by the staff as well as by an institute group.[1]

We began with the idea that the image of long-term foster care held by professionals today is a poor one. We asked ourselves why the literature on the subject is defensive, why the note of urgency? Some of our staff members, in discussing the matter, stated that they were overwhelmed by the multitude of problems in long-time care. They felt guilty for bad placements, frequent moves of children. This feeling was reinforced by constant comments in the literature and in professional discussions that "there is no substitute for the child's own home" or "adoption is the best plan for the child needing permanent care." One young staff member stated that she felt a child in long-time foster care was doomed.

Upon further exploration and review of cases, it became clear that there is a large group of children who will continue to live in foster homes for long periods of time. In some cases studied, this kind of care was, even upon re-examination, the plan of choice. In others, of course, other plans would have been preferable. These included adoption, residential treatment, institutional care and boarding school. The significant observation was that no panacea could possibly cure the ills of planning for the children whose records were studied.

The Problems of Long-time Care

Pursuing the matter of long-time foster care further, we asked these questions: What specifically are the problems of long-time care? How can we understand them? How can we cope with them? In the practice review of records we looked for problems in three general areas—the social, the psychological and the physical. Within these areas we developed a few questions as points of reference in order to build an organized impression from records read. Specifically we were interested in the child's age, sex, date of and reason for placement, and number of replacements. Traumatic experiences prior to placement were noted as were persistent symptoms since place-

[1] New York State Welfare Conference, November 13–17, 1960.

ment, the relationship of natural parents with the child, and quality of foster home or homes.

During the past decade or so, the knowledge content of the fields of child psychiatry and psychology and of child development have grown tremendously through clinical experience and research. John Bowlby, for example, has alerted the world to the importance of mothering and to the hazards for the child resulting from the absence, interruption or ambivalence of mothering. His writings point to the necessity of learning more about emotional deprivation in childhood and about the significance to the child of separation. He has also suggested that the length of time of deprivation as well as its intensity are determinants of the resultant damage to the child.

There were a host of others whose writings stimulated the hypotheses which were formulated at the inception of our practice review of records of children in long-time care—among them Anna Freud, Josselyn, Bender, Levy, Lowry, Goldfarb, Spitz, Littner and Kline, Erikson, Rose, Harlow.

One of our hypotheses was that the age of the child at separation from his parents is a determinant of the symptomatology displayed by the child as defense against hurt. We hypothesized also that the persistence—either in its original form or in modified form—of the symptom which was present at placement, indicates indirectly that we have not helped the child either through casework treatment or through a corrective environment to overcome the trauma experienced prior to or at placement. The implications for practice would thus lie in two areas: First, social workers in the child welfare field must make greater use of the findings of the allied professions so that the impact of deprivation and separation upon the child at given age levels can be better understood and dealt with. Secondly, this increased understanding of the child is a prerequisite in selecting the appropriate type of placement and more specifically the kinds of parents needed by the child.

A "Frozen" Placement Situation

Perhaps the most startling revelation resulting from our case review was that many placement situations of children in long-time care were virtually frozen at the point of placement. It was almost as if the movie had stopped with everyone in characteristic pose. John's case will serve to illustrate this finding.

Today John is twelve years old. He is a slender boy with dark hair, sparkling eyes and a compelling need to be liked. His I.Q. is 140. John and his sister came to live in a Children's Aid Society foster home when he was eighteen months of age and he has lived with his sister in the same home for ten years. He experienced one move from a study home to his present foster family. On the surface, John's foster care experience has probably been better than that of the majority of children in foster care.

The marriage of John's mother and father ended in divorce shortly before placement. Both parents were immature and childish; neither was prepared for marriage and parenthood. The father was a violent man, alcoholic, still dominated by his mother, often escaping to jail. The mother was a dependent, hostile woman whose need for love was so great that she could give little mothering to either child. Her preference, however, was for John's sister. He was identified with his father. John's early history as given by his mother contained no problem. Upon separation from his mother, however, he reacted by vomiting and refusal to eat. He sucked his thumb, feared bed, had trouble with his bath and in going to the bathroom. Toilet training had not been established at the time of placement, since he was only eighteen months old. After placement he showed fear of the potty and often cried for an hour after his bath. By the time John moved to his present home at the age of two, he had established a pattern of somatic defenses against fear and anxiety. At two John was having difficulty with toilet training. Bowel control was finally achieved. At twelve, he still has enuresis.

The record substantiates the fact that John has partially experienced the normal developmental stages of early childhood. For example, when he was four, oedipal feelings toward his natural mother were expressed in addition to more unusual, troubled feelings about her. At six John was proud of being "junior" and was identified with his natural father, at least in fantasy. On the other hand, there has been persistent fear of women. John has continued to be upset by his mother's visiting, has objected to her lipstick, has sometimes vomited after seeing her and is now having difficulty with a female teacher.

It is especially significant that we chose for this child and his sister a "good stable country home":

The foster mother is a large capable woman, the dominant influence in the home. The foster father is a passive, compliant man given to rather solitary activity. The foster mother has never

had a complaint about John. She has, in a sense, condoned his bed-wetting, has never been concerned about the amount of washing that needed to be done as a result of his enuresis. She has accepted him as a likeable, passive boy, nice to have at home and uninterested in the more aggressive masculine play of his peers. The foster father, a rather nonverbal man, has quietly enjoyed John but has been a weak father figure. Now that John is nearing adolescence and his sister is already adolescent, the foster mother's conflicted feelings about sex have been reactivated. At the moment her primary concern is for John's sister, fourteen, who is a well developed, aggressive girl—as aggressive as John is passive. The foster mother, who has recently revealed to the caseworker her fear and anxiety concerning sex, is fearful that John's sister will become illegitimately pregnant. She is not concerned about John's need to be liked and his lack of masculine aggression.

A careful analysis of this case, only briefly outlined here, revealed the lack of diagnostic understanding of John, and of his sister also, at the time of placement. The psychodynamics of the natural family and of the foster family were also inadequately perceived. The caseworker was experienced, sensitive and supporting. However, ten years ago insufficient awareness of the problems, their origin and dynamics resulted in the wrong placement and a "frozen" situation.

It is interesting to note that there was present in the literature at the time of this placement an article which has become a classic. It could have helped us read the signs had it been generally known in the child welfare field at the time. Margaret W. Gerard in reporting on a study of enuretic children had this to say of neurotic enuretic boys: "The boys behaved as if they were inferior to their fellows. . . . (They) disclosed a preponderance of material indicating a fear of women as dangerous persons who could injure or destroy them if they themselves were active." [2] Dr. Gerard found that the boys studied had rejecting mothers and that both boys and girls alike feared harm from the opposite sex.

Summary

This preliminary report of a beginning examination of our practice in long-time foster care is of necessity impressionistic. It outlines in general an approach to a review of practice and focuses attention upon certain important considerations. First of all, there is a growing body of knowledge about childhood which, if better integrated into the thinking of professionals in the child welfare field, could expand our understanding and influence practice in helpful directions. Secondly, the more comprehensive and deep our knowledge and understanding, the greater our awareness becomes that panaceas are the mark of a young profession. Perhaps the answer to long-time care is not its abolition but rather its development. At present, except for the experimentation of a relatively few child welfare agencies, foster care as a service has remained one dimensional. It is all that is left over after adoption, preadoption, specialized foster homes and treatment institutions have been defined.

Surely, if we can study foster home care practice, keeping in mind some of the problems outlined in this paper and elsewhere, the field can develop a differential concept of foster home care. The conviction that such a service is needed is, of course, a necessary prerequisite to its development. Our case review, while it revealed problems of a serious nature, also confirmed that fact that in some situations long-time foster care is the plan of choice. The inquiry quickened our interest in learning more about the following: the relationship of the child's age at placement to the impact upon him of separation from his natural parents, the helpful therapeutic measures for children of a particular age and with a particular problem, and the variety of family or family-type settings useful to children who are best cared for in long-time foster care under the supervision of a social agency. We are alerted also to the danger of "drifting" situations in placements which, because of their duration, often outlive the tenure of staff. Perhaps the most difficult problem of all is produced by the mobility of professional staff.

There is much work to be done to unfreeze long-time care and to develop its potentialities for children. It is certain that if long-time foster care is to develop, professionals must revise their image of it and communities must revise their budgets for children fated to be "orphans of the living."

[2] Margaret W. Gerard, "Enuresis. A Study in Etiology," *The American Journal of Orthopsychiatry*, January 1939.

THE 1960 WHITE HOUSE CONFERENCE ON CHILDREN AND YOUTH—OBJECTIVES AND PERFORMANCE

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The author was vice-chairman of the Mid-century White House Conference on Children and Youth, and also its chairman of follow-up.

APPRAISING the 1960 White House Conference is something like trying to evaluate the United States, for almost anything one says about it could be established as true, partially true, or untrue. The conference was huge, with diverse parts; it stimulated and pleased many, bored a few, and confused some. There were those who attended from a sense of duty, or because they were sent; others came with stars in their eyes and were never disenchanted. Some of the papers and addresses ranked with the best in recent years in social work, public health, and education; others were pedestrian. There were scores of discussion groups; some went well, others were of doubtful value.

The first question to ask in any evaluation is whether or not the activity under scrutiny met the objectives established for it, and of course whether the objectives were sound and realistic. What were the objectives of the White House Conference? I presume they were about the same as those of previous conferences:

To stimulate the states to undertake an appraisal of where they stood in their programs for children and youth and set up new goals for the next decade.

To take a sounding of the national child welfare program and establish guide lines for the future.

To analyze and discuss some of the current knowledge of child care and development, and to add to the literature.

To bring the child welfare cause to the attention of the American people, with special emphasis on the roles of the family, social agencies and institutions, local communities, and states.

Judged by these criteria, how did the 1960 conference measure up? The information at my disposal suggests that, by and large, the states did a good job. Their performance was spotty, but some of it was excellent. In the 1950 Conference, as well as in this one, the involvement of the states was an important feature because of the grass roots emphasis. The real impact of the state programs in 1960 cannot be known, of course, until more time has elapsed.

It is difficult to determine how successful the conference was in evaluating the national program and establishing guide lines. Certain mandates long accepted by child welfare leaders and the rank and file were reiterated and emphasized—and properly so. The several hundred recommendations are diverse, general, and without any suggested priority. Hence, they fail to make the impact that a sharper focus and a real concentration might have produced. Perhaps the main value of the recommendations lies in the procedures out of which they evolved, that is, the participation of the entire conference membership. Let us say that the second objective was realized to a reasonable extent. I saw no clear-cut mandate for the nation emerging from the deliberations.

The pre-conference publication, *The Nation's Children,* was presented in three volumes of high quality and went a long way toward meeting the objective of analysis and discussion of current knowledge of child care and development. Other conference publications include *Children in a Changing World,* a compilation of data from many Federal sources presenting trends in developments and problems; *The States Report on Children and Youth,* a digest of reports prepared for the White House Conference; *Focus on Children and Youth,* a summary of reports issued by national organizations along with a resume of their activities concerning children and youth within the past ten years; *Conference Proceedings; Reference Papers on Children and Youth;* and *Children and Youth in the 1960s,*

which gives information about the current status of young people as well as surveying existing programs, research, prospects and needs.

This objective was met more fully than the second, in my view. I would give the conference a good mark here.

Bringing the child welfare cause in an effective way to the attention of the American people is a big and highly difficult task. Certainly the many thousands of people who were involved in the conference in various ways felt the impact and passed it on to others directly and indirectly. But there is no evidence that the conference itself, its findings, its papers, or its recommendations have made any considerable impression on the public or on public policy as yet. Here again we must wait a year or two for a fair evaluation—and even then it will be a matter of judgment. This objective is less definitive than the others and hence it is more difficult to determine just how the conference measured up to it. But at this point I believe the conference cannot lay claim to any great success in this respect.

It is possible that the objectives as stated here are too ambitious; it is clear that before long, and certainly well in advance of another conference, there should be a careful review of objectives and of program and structure in relation to them.

To accept the involvement and active participation of a large number of people of different ages, professions, and geographical locations as a desirable objective, does not mean necessarily that we must bring 8,000 or more people to a central meeting place at one time. There might well be more activity involving more people at the state level and only a small number of delegates from each state actually attending a central meeting. Simultaneous White House Conferences in every state might accomplish more than one gigantic conclave.

In sum, the 1960 White House Conference produced some sound additions to the literature; it engaged a large number of adults and notably young people in a significant enterprise; it reactivated some old and started some new statewide programs. In retrospect it seems wise to urge strongly a full evaluation of the 1950 and 1960 conferences, a weighing of the pros and cons of any large conference of this kind, and an objective consideration as to whether a conference of huge proportions is the best way to invest funds and staff time in improving the status of child welfare. One hopes that the Conference Follow-up Committee will address itself to these questions.

The leadership and the staff of the 1960 conference are to be congratulated on the manner in which they organized and conducted a large meeting, or rather a series of simultaneous meetings. Those who attended must also be commended for their dedication, patience, and cooperation.

The adults and young people who labored and who still labor in the states and local communities are the real and largely unsung heroes of the drama. They include that great company of earnest but unknown parents, teachers, and professional workers who form the backbone and the flesh and blood of our entire child welfare program. Increasingly our conferences, both large and small, should be built around their needs and take advantage of their wisdom and dedication.

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SOME LESSONS LEARNED IN DEVELOPING A RESIDENTIAL TREATMENT CENTER

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The Junior League of St. Louis received the 1960 Edith L. Lauer Award for its pioneer efforts in establishing and supporting a residential treatment center. Much of the development described here was made possible through those efforts.

In recent years, the challenge represented by the unmet needs of children with severe emotional disturbance has led to the development of residential treatment services.[1] The need for additional services of this nature is now quite apparent. The experience of Edgewood Children's Center may be helpful to those interested in developing such a program.

As a recent study shows, residential treatment facilities have been and are being created in response to community recognition of gaps in existing services and the unmet needs of emotionally disturbed children.[2] There are many different applications of the concepts underlying residential treatment. But according to a now-classic descriptive study, residential treatment centers "have one thing in common—the development of a total approach to therapy. Individual psychotherapy with the child and his parents, a therapeutically designed living experience and remedial education are all seen as parts of a whole." [3]

The two major patterns of development of residential treatment facilities have been the modification of existing programs, generally institutions, and the creation of residential treatment centers as new agencies. Edgewood Children's Center developed according to both of those patterns, as well as a third pattern which may be of considerable current importance—a merger of two existing organizations.

The current program of Edgewood Children's Center is the result of a merger, in 1956, of the original Edgewood Children's Center and the Forest Park Children's Center. Old Edgewood, as we now refer to it, had in its long history reflected the many changes in the development of child welfare practices. The shift from "providing care to providing psychiatric help for children with emotional problems was the first step in the evolution of several child care institutions" into treatment centers.[4] This was Edgewood's pattern. The Forest Park Children's Center, on the other hand, had been created specifically to provide residential treatment. In many ways, it resembled, and to some degree utilized the treatment philosophy of, the Ryther Child Center in Seattle, Washington.[5]

Each of the two St. Louis agencies had a tradition of concern for the welfare of emotionally disturbed children, and had developed its own program of service. Although it might have been preferable to further develop each agency as a separate treatment center, the limitation of both agencies and the inability to obtain financial support for two such treatment programs necessitated the merger.

Experience with Purchase of Service

Like many of the other institutions in the St. Louis area, Old Edgewood had used what may be called the "purchase of service" approach to providing clinical services. In the development of residential treatment perhaps this first step was needed. It is still being practiced by many agencies, either as a step toward further development or as an accepted part of practice. The experience at both Edgewood and the Forest Park Children's Center points to deficiencies in that arrangement.

[1] Donald A. Bloch, *et al., A Study of Children Referred for Residential Treatment in New York State,* A Report to the N.Y. State Interdepartmental Health Resources Board, Albany, N.Y., January 1959.

[2] Martin Gula, *Child Caring Institutions,* U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau Publ. 368, Washington, D.C., 1958.

[3] Joseph H. Reid and Helen R. Hagan, *Residential Treatment of Emotionally Disturbed Children—A Descriptive Study,* Child Welfare League of America, New York, 1952.

[4] *Psychiatric In-patient Treatment of Children,* American Psychiatric Association, Washington, D.C., 1957.

[5] *Monograph on Organization and Operation,* Ryther Child Center, Seattle, Washington, January 1948.

This does not mean that agencies currently using this plan are subject to criticism, but that a closer examination of the method is necessary.

Under the purchase of service procedure, the children who are living in the residential treatment center receive their social service from some other agency—usually the referral agency—be it a family service agency, a child guidance clinic, or a placement service. One might refer to this as extra-mural social service. It must be differentiated from provision of clinical services by an agency from a downtown or a central office for children in residential units elsewhere.

In a *Study of 16 Children's Institutions of St. Louis and St. Louis County* in 1954, it was revealed that the use of extra-mural clinical services generally created many problems with regard to the integration of the services of the institution with those of the agency providing the casework service.[6] There was the constant problem of inter-agency communication and relationship, which often meant delays, misunderstandings, confusion and inconsistency. Nor was it at all economical as a plan of action. The agencies receiving extra-mural services did not have to account for them within their own budgets, as they were in a sense borrowed services. Still the cost was being borne by the community at large.

Even before the time of the report referred to, Dr. Bruno Bettelheim, lecturing at Washington University Medical School in St. Louis, deplored what he referred to as a "cold storage" approach to the treatment of children in institutions. He indicated that the clinical interview was only a very small fraction of a child's total time in care and that it was too frequently divorced from group living experiences. In a treatment center, treatment is of necessity brought about by the combination of the various interactions and relationships in order to achieve the resolution of problems and the corrective experience of living in a social community.

Edgewood, a community chest agency seeking to obtain its own built-in services for children in its care, had children in need of varying degrees of service. Some were primarily in need of treatment—others needed the placement as such. There seemed to be a failure to understand the significance of the group living experience itself as a treatment experience which must be utilized along with and coordinated with the individual therapy. The isolation of the therapeutic relationship implied that the environment need only be benign. In a sense, the agency failed to realize the potential contribution that the group living experience could make to the therapeutic process.

The same approach had been used with only slight modification in the early days of the Forest Park Children's Center, which the Junior League established in 1946 and thereafter supported. The purposes of the center at the beginning were to be a home for the study or observation of emotionally disturbed children, and a diagnostic center from which children could be referred again to a suitable facility for continued treatment. But the center found that study and treatment are part of a continuum, that diagnosis and treatment are intricately related to each other. In addition, it recognized that separation of the child from his home by placing him in a study home was itself a painful experience, and that separation and placement in still another treatment facility was again traumatic. Probably as traumatic for all concerned was the inability to find within the community other facilities, particularly residential units, for the continued treatment of the children.

Forest Park Children's Center thus became a treatment service. At first it hoped to provide a short-term treatment experience, but gradually accepted responsibility for providing a more flexible plan of treatment including, in some instances, long-time care. At first, most of the casework service was provided on an extra-mural basis. This, however, was modified relatively early in the agency's history. Responsibility for intake was shared with the referral agency, but the decisions as to admission and discharge were those solely of the treatment center. Consultation and treatment plans were designed by the center. At the outset, the center was to work with the child, the referral agency with the parent. This too was abandoned, and the center assumed total responsibility for the family unit.

[6] *A Study of Sixteen Children's Institutions in St. Louis and St. Louis County*, Social Planning Council of St. Louis and St. Louis County, St. Louis, December 1954.

Ways of Providing Clinical Services

Agencies which become interested in serving disturbed children—either becoming treatment-oriented or developing into actual treatment centers—frequently take these steps to provide clinical services: they add a psychiatric consultant, use the purchase of service approach which we have already mentioned, or superimpose a child guidance clinic on an institutional setting. Forest Park Children's Center used all of these measures, with varying degrees of success.

The *addition of a psychiatric consultant* does not in itself make the agency a residential treatment facility. The consultant, unless he is aware of the meaningful qualities of the group process and the use of the total environment, may all too frequently tend to direct treatment in a highly individualized way, responding to what occurs within the relationship of the therapist and the client. The child is sometimes protected against the expectations of the environment and so the reality is modified. At times, it would be to the better interest of the child to adjust to the reality around him.

At the Forest Park Children's Center, the psychoanalyst consultant, Dr. Conrad Sommer, developed what was considered to be psychoanalytically-oriented group living with individual therapy.[7] Some of the analytic concepts were tested out and modified. Thus, for example, the degree of permissiveness normally applied to behavior was modified in the interview situation, and drastically so in the living situation. This was based on the needs, capabilities and behavior of the kind of group in residence: more and more, the residential treatment center became a service for children with problems of impulsivity, hyperaggressiveness and acting out behavior.

Thus, the value of the psychiatric consultant depended in large measure upon his recognition of how the total environment could be made something actively therapeutic in relation to the client in current care. The effective use of the consultant depended upon the size and composition of the groups being supervised, the competence of the staff and their ability to utilize the help of the consultant and to carry out his treatment recommendations. Consultation was regarded, and correctly so, as a means of training the various staff members in a difficult but gratifying task. Despite turnover of staff and changes of administration and the various other problems faced by the agency, the constant support and guidance offered by the psychiatric consultant in an objective and facilitating manner preserved the integrity of the residential treatment program at Forest Park Children's Center.

The *purchase of service approach,* used in the early days of the agency, had a number of drawbacks. In addition to the fact that a number of different workers were involved with the children in residence, there was a wide range of skill. Also, the outside social service staff experienced many frustrations. They were unable to identify themselves as integral elements of the agency. Only rarely was such an "outside" worker regarded with the degree of affection reserved for members of the team.

This problem of outside services was present in connection with other aspects of program, especially education and medical care. An increasingly larger proportion of the children coming into care had histories of learning disabilities, truancy, and other school-related problems. Most children were able to attend community public schools, with which the agency worked very closely. For those having very severe school problems, special arrangements were made with private schools to offer tutorial experience or participation in small class groups. There was value in this approach, but again it was very difficult to coordinate the effort of the center and these schools. Treatment goals of the group needing such educational help made this an important aspect of the program,[8] but the cost of such schooling became rather prohibitive. As in so many other instances when it was necessary to demonstrate the value of a new project, the Junior League provided funds for the employment of a teacher, and education of a special nature became a built-in part of the residential treatment program.

The medical situation was somewhat more complex. Each child received medical care

[7] Conrad Sommer, "Psycho-analytically Oriented Institutional Treatment of Children," *Diseases of the Nervous System,* November 1950.

[8] Samuel P. Berman, "The Institution and the School," CHILD WELFARE, June 1957.

through his own referral agency by way of their clinics. This meant great inconvenience, much loss of time and effort and little or no opportunity to make use of the medical profession as part of the treatment team. In time, the center retained on a contract basis the services of a pediatrician who served thereafter as medical consultant to the agency. This too, was significant modification in philosophy and methodology of the treatment center approach.

The practice of *superimposing a child guidance clinic upon an institutional setting* was never fully accepted, nor engaged in, by the Forest Park Children's Center. For about one year there was a close affiliation with a child guidance clinic. Under this arrangement a psychiatric resident in training was assigned as therapist to several of the children at the center. For various reasons, including the divergent views as to what constituted residential treatment, the plan was later terminated. Had there been greater recognition of the environment itself as an active aspect of the treatment situation, perhaps this demonstration could have been continued for a longer time.

Should the Executive Do Therapy?

There was an unusual problem stemming from the pioneer nature of residential treatment at the Forest Park Children's Center which may have some applicability to other agencies interested in becoming treatment centers. The agency operated on a shoestring budget. For lack of experience with such a service, an unrealistically low budget had been set up. This meant a very limited kind of staff quota, so that almost all of the staff had at least dual roles. For example, it was the practice for the treatment of the children and parents to be provided by the executive director of the agency. This individual was, throughout the history of the agency, a psychiatric social worker operating under direct supervision of the psychiatric consultant. While a purchase-of-service approach was being used, the executive director provided much of the supplementary treatment services. After discontinuance of the extra-mural plan, he provided all of the treatment services or else supervised students who carried a small case load.

Even in the earlier days, there were misgivings as to the amount and kind of role confusion involved. There was great doubt whether an individual could be both an administrator of the agency, therapist for the children in care, supervisor of staff members, person in direct contact with the parents of the children, setter of agency goals and expectations, and community representative of the organization. In addition, he was sometimes called upon to be part-time secretary, and occasionally a relief houseparent. This was a task which provided unique training opportunities and unusual proximity to the inner workings of the total program in a small agency serving no more than a dozen children at any given time. It was possible to learn how to clarify for the children and for the staff the different roles of the executive director. However, there were some very regrettable drawbacks. The executive director was not free to be a full-time administrator nor a full-time supervisor nor a full-time therapist, so that there was a great fractioning of responsibility, and also excessive strain on the director.

This may not answer the questions of some institutions as to whether it is advisable for an executive of a residential treatment center to be the therapist for some clients. It may be argued that continuation of some treatment practice helps retain or sharpen skills. It raises many questions too, of course, such as: what occurs within the group when the executive has some children in therapy and not others? How does the staff view those children? Is the child care staff conflicted about his therapeutic relationships? It would be interesting to study this further.

One conclusion that must be emphasized is that the responsibility of the administrator of the residential treatment center should be regarded as a full-time responsibility. The time and effort that go into the planning of a program are of vital importance to the total group and to the individual client. To diffuse that role too much limits the value of the administrator in a way that may ultimately be productive neither for the agency nor the community at large. Similarly, the therapist should not have additional responsibilities that would vitiate the primary job. With increased awareness and understanding of the

problem of role clarification and role confusion, with greater recognition of the dynamic factors and the unconscious elements active in relationships within a treatment organization, some of the past practices need not be repeated.

What Residential Treatment Requires

From the experiences of both agencies, some points of philosophy about residential treatment became quite clear. One of the basic requirements is the conscious use of the total environment in a goal directed manner, that is, with a combination of individualized treatment and a structured group living setting. This would include the planned use and selection of personnel to establish meaningful relationships, to meet dependency needs, to set patterns for identification, to enable increase in attention span and frustration tolerance, to control impulsivity, to internalize limits and to develop more wholesome and adequate defenses.

The methods would include the use of the total team, consisting not only of the traditional clinical staff but of all co-workers dealing with the youngster. This makes the selection of staff, their training and supervision vitally important. Because of the number and kinds of staff members involved in this complex setting, there must be clarification of responsibilities and roles. In general there must be a high degree of communication, both formal and informal, as well as clear-cut supervision, in-service training and integration efforts. The team approach would involve not only decision making but implementation.

The setting itself in which this occurs would have to be an accepting climate geared to offering security, protection, consistency and predictability to children brought to the attention of the agency. It would have to be, on a day-by-day basis, a corrective living experience. Dr. Irene Josselyn has referred to the importance of child care staff and therapy staff maintaining an attitude of "confident expectancy" about goals set forth for individual children and the group. An important responsibility of a treatment setting is to insure for the child confident expectancy as to the relationships with, and the behavior of, the adults responsible for his care.

The personnel who make treatment effective consist of the consultant, the therapist, the houseparents, the teacher, the recreation worker, the group worker, the maintenance staff, the administrator and at times the peer group. This team has to have conviction of a bull-dog variety, that is, the tenacity to stand by a child through the various upheavals that he is bound to experience. Once a child is accepted, he should be guaranteed the security of the agency with certain rights of tenure and clear-cut protection against the experience of premature removal or rejection.[9]

The Program of Edgewood Children's Center

Edgewood and Forest Park Children's Center were merged on the recommendation of the St. Louis Planning Council, in the belief that by combining staff and experience of the two agencies, and making use of cottages recently built by Edgewood to replace its old building, an expanded treatment program could be provided. It was agreed to restrict the size of the agency until the treatment center program could be developed further.

The center now has a capacity of twenty-four children in residence. Each year, through its diagnostic studies, after-care, work with parents and resident group and day school clients, it provides service for a total of eighty to ninety clients. The total staff of Edgewood consists of the executive director, who is a psychiatric social worker, a director of casework assisted by two caseworkers, a psychiatric consultant and a psychologist, the equivalent of seven child care workers, a group care supervisor, a teacher, a student group worker, a maintenance staff of six, a secretary and a part-time bookkeeper.

Referral sources are mainly the social agencies, schools, courts, physicians, clinics and parents directly. The institution is nonsectarian. Geared primarily to pre-adolescents, it accepts boys and girls who are five to twelve years old on admission. They are of at least average intelligence; children with emotionally inhibited intelligence may be accepted. The agency does not accept children with severe organic damage or severe physical handicap, and usually does not accept psy-

9 Sidney N. Hurwitz, "The Child Who Belongs to Himself," *Social Work*, January 1960.

chotic children, although this would depend upon the type and degree of disturbance. The children treated include pre-psychotic and neurotic youngsters, and those with arrested ego development, character disorders and behavior disorders. Most are hyperactive, acting-out children; some may be severely withdrawn. Symptoms include truancy, lying, stealing, soiling, enuresis, night terrors, learning difficulties, fire-setting, sadistic behavior, suicidal tendencies, exhibitionism, tantrums, tics.

During the referral process, the basic question is: "Is residential treatment the treatment of choice?" Children who cannot be treated in their own homes, who require a controlled but somewhat permissive setting, and for whom another institution or a foster home is neither indicated nor available are considered for placement. The assessment is based in large part on a child's capacity to relate to adults and to children. Not infrequently, a child will be accepted for treatment primarily because he is without roots, a child who has been moved too often.

The treatment itself begins with the intake study. There is careful selective screening and preparation of children and parents. The social history is obtained in interviews at the agency and through home visits and family observation. Other sources of information are psychological tests, medical examinations, neurological examinations if indicated, school reports and psychiatric interviews. Pre-placement visits to Edgewood for orientation and diagnostic purposes are essential parts of the program. The final points in the referral are clarified at the inter-agency admissions conference, after which the family is further assisted in working out details of the plans.

Edgewood is housed in two modern cottages, each containing two units. Within each unit, six children live under the supervision of one houseparent. Considerable use is made of the experiences of living in a community with its schools, churches, organizations and activities. The center provides much permissiveness with reality limitations, or freedom in an elastic framework. Children attend the public school if at all possible. However, for those who are academically retarded or whose behavior disturbances are too severe to be tolerated in public schools, the agency maintains a small school on the grounds, which is conducted as a remedial program by the Special District for Handicapped Children in St. Louis County. The Special District supervisor participates in case conferences concerning the on-grounds school children.

The children have group work sessions,[10] and life space interviews of an ego-supportive and interpretive nature. In addition, they have casework interviews twice a week or more, depending upon their need and readiness for more formal intensive treatment. The psychiatric consultant meets with the total staff at case conferences each week, and gives additional time for staff seminars as part of the in-service training of staff. The psychological consultant provides testing and retesting for all the children, and because of her experience and training is consultant to the therapy staff, meeting with them for a half day every other week. In addition, each of the four units has a weekly unit meeting attended by the various personnel serving it.

It has been demonstrated, since the agency reorganization in 1957, that the average length of stay of a child will be about three years. More than half the children have been returning to their own homes, the next largest group go to foster homes, and some children have to go on to other institutions. A few children may be adopted. Follow-up care for child and parent is provided for about six months after discharge.

Because of the inadvisability of terminating treatment abruptly, and because of the importance of the after-care placement of the child, Edgewood has now initiated plans to establish a group foster home on a halfway-house basis. The unit will provide a community residence for children in an agency owned and operated home within a few miles of the institution, in the same suburban community. It is believed that this halfway-house will serve to gradually expose children to the less sheltered experience of community living. Casework services will be provided through the center.

The cost of the residential treatment center program is approximately $6,000 per child per

10 Samuel P. Berman, "Group Work in a Merged Institution," CHILD WELFARE, May 1959.

year; this figure is based only on service to those children who reside in the institution. Approximately three-quarters of the budget comes from the United Fund, the rest from fees and a small endowment. We believe that we have demonstrated that our treatment services have preserved human values and contributed to the well-being of the child and the community.

In Conclusion

One of the major convictions built up over the years in observing residential treatment is that it must be part of a network of services. For this reason, the establishment of a treatment center through merger or affiliation of existing agencies would seem to offer much help in strengthening, and making more available, residential treatment services for children who need them. In the case of Edgewood Children's Center, a stronger residential service was created by the merger of a nurturing institution and a treatment center. It is also possible to envision a treatment center and a placement agency, or a clinic and a treatment center, combining their services.

Among the lessons learned during the gradual evolution of residential treatment in St. Louis were that residential treatment must utilize a planned program with built-in resources, that diagnosis without treatment is of only limited value to the severely disturbed child in need of residential care, and that the environment must be utilized constructively to facilitate treatment. Much of the development described here was made possible only by the willingness of the Junior League of St. Louis to sponsor and sustain new programs to meet the needs of emotionally disturbed children. Their patience and persistence has helped demonstrate the effectiveness of residential treatment.

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The National Conference on Social Welfare

A reminder to our readers—The National Conference on Social Welfare will be held this year in Minneapolis, Minnesota, from May 14 to 19.

SPECIALIZATIONS WITHIN THE FOSTER PARENT ROLE: A RESEARCH REPORT

PART II: FOSTER PARENTS CARING FOR THE "ACTING OUT" AND THE HANDICAPPED CHILD

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What are the qualities agencies should look for in foster parents when placing children with special problems?

The research project described in the following article shows that:

. . . foster parents who have had children of their own appear best suited to care for "acting out" children and physically handicapped children.

. . . the foster parents who are democratically oriented appear to be more successful with aggressive children.

. . . foster parents who are especially responsive to dependency needs in children fare better with the physically handicapped and mentally retarded child.

. . . foster parents from clan-type families show a greater readiness to accept the physically handicapped and mentally retarded child.

In the first part of this article, it was suggested that one plausible way of differentiating among foster parents was to distinguish those occupants of the role who devote themselves to the care of infants from those who were inclined to serve the somewhat older foster child, i.e., the child three years of age and older.[1] Some differences in social adaptation and role orientation of these two groups of foster parents were set forth, and it was hypothesized that foster parents of infants were motivated by rather personal kinds of role satisfactions as opposed to the more social gratifications of the foster parents of older children.

The Care of "Acting Out" Children

As has been previously pointed out, a challenging task for most child welfare agencies in recent years has been that of recruiting foster homes that can be developed for the care of the apparently increasing number of emotionally disturbed children now coming into placement. Kline has discussed the considerable thought that must be invested in the selection of the foster parents who can tolerate bizarre and unusual behavior in children who, in their young lives, have been buffeted about from one home to another.[2] In this connection, it is of interest to examine the manner in which the caseworkers in this study perceived the suitability of foster homes for various kinds of children with special problems who require care outside of their own homes. These perceptions were recorded on the special rating instrument prepared for this project, the Foster Parent Appraisal Form (FPAF).[3]

The caseworkers in this study were asked to rate foster parents known to them in many areas considered important for successful role performance, e.g., methods of discipline, reactions to various types of children, family interaction. The question arose as to what might be the relationship of one variable to another in the rating form. To determine this, some forty variables of the FPAF were intercorrelated and these correlations were submitted to a statistical procedure called factor analysis. This procedure enables an investiga-

[1] Part I, "Differences between Foster Parents of Infants and Foster Parents of Older Children," CHILD WELFARE, March 1961.

[2] Draza Kline, "Understanding and Evaluating a Foster Family's Capacity to Meet the Needs of an Individual Child," *Social Service Review*, June 1960, pp. 23–35.

[3] Discussed in Part I of this article. (CHILD WELFARE, March 1961).

tor to determine the manner in which ratings tend to cluster together. Thus, it was found that the forty variables on which the foster parents were rated could actually be condensed to six key aspects of their role performance. One of these factors centered about the general ability of foster parents to care for the "acting out" child. Table 1 sets forth the loadings of the variables which were linked together in this factor.[4]

TABLE 1

FACTOR DESCRIBING FOSTER PARENTS' ABILITY TO PROVIDE CARE FOR "ACTING OUT" CHILDREN

Variable		Loading
1.	Foster family is described as being suited for an aggressive youngster who is reportedly fresh to grown-ups	.53
2.	Foster family is described as being suited for an adolescent girl who is sexually precocious	.52
3.	Foster parent is described as being responsive to child nine to twelve years of age	.45
4.	Foster family is described as being suited for a youngster who shows bizarre behavior	.41

Thus, within the same cluster of ratings were those variables referring to the ability of foster parents to provide care for the "fresh" youngster, the sexually precocious adolescent girl, the child who shows bizarre behavior and the older child, aged nine to twelve years.

A Portrait of Highly Rated Families

Scores were assigned to the 101 families who were included in the study based upon the ratings assigned them on the four variables making up the "care for acting out children" factor. A portrait was thus developed of families who scored high in their capacity to absorb this kind of a youngster.[5]

It was found that those subjects who, according to the caseworkers' ratings, seemed able to provide a high level of care for "acting out" children were apt to have had ample experience with children of their own. These subjects also received ratings from the caseworker which indicated, in a general way, what might be referred to as good ego functioning in the parent role. That is, according to the caseworkers who knew them, they demonstrated appropriate warmth, showed understanding of children's emotional needs, had little need to exploit children for neurotic purposes, etc.[6] These families were also seen as being more democratic in their family relationships (r=.39) and scored high on a factor measuring their identification with the foster parent role (r = .25).

The foster parents who achieved high ratings with respect to their capacity to care for "acting out" youngsters also appeared to be more deeply integrated within their communities than those who achieved low scores. They were more apt to be intimately acquainted with key community figures, to know their immediate neighbors well and to actively socialize with them. The correlation with a Neighborliness Scale developed by an anthropologist on the research team was .30.[7] Upon reflection, it makes sense to assume that if a family is going to accept for placement a foster child who has a propensity for aggressive "acting out" behavior, the members will need to enjoy secure relationships with those in close physical proximity to them in their communities who are apt to become targets of the child's negativistic behavior.

The role of the foster father appears to loom particularly large when caseworkers consider plans for the aggressive foster child. It was found that the foster fathers in high scoring families had relatively little deprivation in their childhood backgrounds compared with fathers in those families deemed not suitable for such children. That is, they were less apt to have suffered the death of a parent or other forms of parental deprivation as youngsters, the economic status of their families tended to be adequate, and they were more apt to report that their parents had been affectionate to them and appeared happily married.

At the same time, the foster mothers in this group were apt to view their husbands in a more positive way, as revealed by their responses on the PARI scale, Inconsiderateness

[4] The "loading" of a variable on a factor constitutes the correlation between the variable and the factor. The higher the loading, the more the variable helps to define the general meaning of the factor.

[5] Summated scores were weighted according to the loading of each variable on the factor.

[6] The correlation between the "ability to care for 'acting out' children" factor score and a factor measuring parental ego strength was .52. For this size group a correlation (r) of .22 would be considered significant at the .05 level of probability.

[7] Otto von Mering, "The Neighboring Patterns of Foster Parents," presented at the National Conference of Social Welfare, Atlantic City, New Jersey on June 7, 1960.

of the Husband.[8] These women were also apt to avoid harsh attitudes in their child-rearing, as indicated in their responses on the PARI scale, Strictness.

All in all, one is impressed with the fact that the casework staff appears to have identified what might be considered a premium group of foster parents. Being a fairly stable group with little deprivation in their backgrounds and having solid ego structures, they emerge as those foster parents best able to undertake the most arduous kinds of placements.

The Care of Children with Biological Handicaps

Another cluster of caseworker ratings of foster parents that emerged in this study was one related to the capacity of foster families to absorb physically handicapped or mentally retarded children. The loadings of variables on this factor are shown in Table 2.

TABLE 2

FACTOR DESCRIBING FOSTER PARENTS' ABILITY TO PROVIDE CARE FOR CHILDREN WITH BIOLOGICAL HANDICAPS

Variable		Loading
1.	Foster home is described as being suited for a mentally retarded child	.82
2.	Foster home is described as being suited for a child with severe physical handicap	.76
3.	Foster home is described as being suited for an infant suffering from colic	.55
4.	Foster home is described as being suited for a youngster who shows bizarre behavior	.36
5.	Foster mother is described as *not* being motivated in assuming the role of foster parent by the factor of feeling less feminine with the absence of children	(—) .35*

* The original sign of the variable in the factor table is indicated in parentheses when the meaning of a variable has been reversed. The negative sign (—) in front of the loading in this instance refers to the absence of a particular condition when the other variables are said to be in operation.

It is of interest to find that the caseworkers' ratings tend to link together the abilities of foster parents to provide care for three kinds of youngsters coming into placement: the physically handicapped child, the mentally retarded youngster and the child who is emotionally disturbed (i.e., shows bizarre behavior). When one also includes the infant suffering from colic, it becomes apparent that the element that links these children together is their essential *dependency*. The inability of these children to fend for themselves—often because of constitutional limitations—in many situations with which normal children can cope, may be the ingredient that appeals to some foster parents. This concept of being oriented toward dependency needs is reinforced by the finding of a significant correlation of .45 between the factor score based on ability to care for handicapped children and a factor score relating to the usability of the foster home for babies. Furthermore, there is a significant negative correlation between the factor score on ability to care for handicapped children and the median age of the foster children who have been placed in a home, thus indicating that the caseworkers' ratings are supported by *actual* patterns of placement in these foster homes.

The caseworkers' ratings revealed one major psychological variable that was associated with the ability to provide care for the handicapped child: the foster mother's motivation in taking on the role was not related to her need to compensate for feeling less feminine without children around her. Obviously, a foster mother with a vulnerable ego structure might well find the burden of a mentally retarded or physically handicapped child too difficult to carry. The child's disabling attributes might easily loom as a threat for a person whose own self-image is already weak, and who fears that the social stigma suffered by the child will be passed on to herself as the parent figure.

As with those described as being able to provide care for the "acting out" youngster, the foster parents whom caseworkers rated as having the capacity to care for the handicapped child tended to have had the experience of caring for a number of their own children before becoming foster parents. It is interesting to note that foster parents who had not had children of their own showed a tend-

[8] Parental Attitude Research Instrument, developed at the National Institute of Mental Health. This was another basic source of data in the study.

ency to avoid foster children who made unusual demands with respect to their physical care, or because of their behavioral difficulties.

Deserving special attention, however, is the finding that, unlike the foster parents for the "acting out" group, these foster parents were not rated by caseworkers as having high levels of ego-functioning as parents, nor a democratic orientation in their family relationships. This is to say that they were not rated as being particularly warm or devoid of neurotic qualities, other than in the area of successful resolution of their feminine identifications. These ratings by the caseworkers were validated to some extent by significant positive correlations between the factor scores re handicapped children and scores achieved by the foster mothers on two PARI scales, Deification of the Mother and Suppression of Aggression, which measure authoritarian tendencies in the mother.

The benevolent authoritarianism of the foster mothers in these cases was often associated with ratings of the foster father as suitable for a child in need of a *strong* father figure. It would appear that the ability to care for the physically disabled or retarded child, or the child with bizarre behavior patterns, is often associated in the caseworker's mind with a certain kind of exterior toughness on the part of *both* the foster mother and the foster father. Evidently the care of these children is seen as a task that requires "doing" kinds of people who can take over to some extent, rather than people who are more democratically oriented and who thus tend to "take over" less. Whether this orientation of the caseworkers in this project, as revealed by their ratings, is a sound one is open to question. Warmth and the ability to accurately perceive the needs of the child may be needed more by the handicapped child than by the youngster who is not so afflicted.

It should also be noted that the ratings of the caseworkers regarding the ability of the foster parents to provide care for these children are significantly correlated with self-estimates made by the foster parents. The correlation between the rating score and a scale based upon direct interviews with the foster mothers, Capacity to Cope With Problems of Foster Children, was significant. The scale consisted of seven questions about various kinds of problems of foster children, and the foster mother was asked to indicate whether she felt the problem was of an *easier* kind, *harder,* or of a kind she absolutely could not accept. Thus, it would appear that there is some measure of agreement between these role partners in the placement agency (i.e., caseworkers and foster parents) regarding the allocation of children to the foster homes. The subjects appeared to be getting the kind of children they desired.

A Sociological Characterization

By way of a sociological characterization of these foster parents, it was found that foster parents who were deemed suitable for handicapped children came from what might be described as clan-type families. That is, their families were large, closely knit, and tended to meet together often for large family occasions—weddings, funerals, etc. Whether the clan-type family provides its members with added social supports, which thus enables them to take on child rearing tasks which the smaller family units would find more difficult to assume, is a matter for conjecture. It is also possible that the clannish family is one that places value on *all* family members to the extent that the presence of a handicap would not tend to be a factor which would exclude the individual. This value orientation may play a part in the willingness of such individuals to take in handicapped foster children.

In this connection, it was of interest to find that foster parents coming from clan-type families showed greater difficulty in separating from foster children than did those who come from smaller, less extended family systems. The writer had originally hypothesized that the opposite would be the case: that those coming from large family systems would better tolerate the loss of a child because of the lessened sense of intimacy that characterizes large social units. However, upon reflection, the finding seems quite plausible when one realizes that a major dynamic of clannish families is the fact that they need to vigorously hold on to every member, even distant cousins!

One incidental finding about the sociological characteristics of foster parents who in direct

interviewing indicated an unwillingness to take care of foster children with handicaps, is of interest. Foster parents who came from rural backgrounds showed a noticeable reluctance to care for the handicapped child. It has been suggested to the writer that perhaps this attitude relates to the economic necessity of farmers to destroy farm animals who are born with physical anomalies, and that perhaps this has helped create a general psychological set against all disabilities of living creatures.

One final element in the portrait of families considered suitable for the disabled child concerns their adaptation to the foster parent role. These families were rated by caseworkers as more strongly identified with the role than those caring for the more normal child. This finding is based upon a number of items in which the foster mother was asked the length of time she intended to continue in the role, the conditions under which she would find it necessary to abandon it, and the centrality of the role within her total life-space.

The Areas of Specialization

The data reported in both parts of this paper suggest meaningful dimensions along which foster parents can be categorized. These dimensions relate to the characteristics of foster children for whom foster parents appear best suited. A basic division of labor exists between those who can provide care for infants and those who can take older foster children into their homes. While these are not necessarily mutually exclusive categories—some foster parents can provide care for children of diverse ages—the tendency, nevertheless, appears strong for sub-specializations to take place within the role based upon the age variable.

The other dimensions that are suggested by our data indicate two other areas of specialization: care of "acting out" youngsters and care of biologically handicapped children. Foster parents capable of caring for the former are also those who are most often regarded by caseworkers as being able to provide care for the so-called normal *older* foster child. On the other hand, the care of the biologically handicapped child is perceived by caseworkers to be more often the kind of task that is most satisfactorily undertaken by foster parents who care for babies. It has been conjectured that they are essentially attracted to the more pronounced dependency of the very young or of the disabled foster child. Here too, we find that these are not mutually exclusive categories.

Some families are probably so strong in their sense of solidarity and in the ego strength of the individual members that almost any child could be placed with them. These are the small core of almost "professional" foster families that have become visible to agencies. The reasons for their versatility should become the object of further research.

Discussion

In the research reported here and in other studies of parent behavior, it has become clear that parenthood cannot be studied in isolation from childhood. On the face of it this seems like such a commonplace statement as to be almost banal. Yet, parents and foster parents are very often assessed as if their characteristics can be separated from those of the child under their care. Many of the foster parents in this study showed quite a broad range of behaviors with the foster children placed with them. One kind of child could evoke a positive, nurturing kind of response while a child with different characteristics could bring forth almost rejecting behavior from the very same foster parents. While we would expect that foster parents who have solid ego structures and sound superego values would do uniformly well with most children placed with them, their parental capacity must nonetheless be seen as a varying phenomenon.

The aim of high-level casework practice should be to maximize the parental potential through 1) the placement of children who can evoke the most positive response and 2) the provision of supportive help by caseworkers to foster parents to help them withstand the negative and often seemingly unchangeable behavior of upset foster children. The factor analysis reported here appears to point to clusters of traits of foster parents who can care for several types of foster children (i.e., the biologically handicapped child, the "acting out" child, etc.). These findings should be tested further to determine whether they will replicate in other settings.

THE HARD-TO-PLACE CHILD*

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How one adoption agency opens doors to placement.

THE welfare of the hard-to-place child is of great concern to every child placement agency in the world today. We might ask ourselves: "Is he really a hard-to-place child or is he just different? Is the problem of placement his or is it ours?" Placement of children is our problem and finding families for these particular children is difficult for us. However, much depends on our own attitudes toward the child who is different or unusual because of his background, appearance or a medical disability. Considering him hard to place may focus attention on him as a liability and on what we will do *about* him, rather than on what can be done *for* him.

Most of the children placed in adoption by Spence-Chapin are three years of age or under. Many of our children are placed five days after birth, directly from the hospital. However, the agency accepts referrals for adoption placement of children of all ages from other agencies. So far, the oldest child we have placed in adoption was thirteen years old at the time of placement.

Although many of these children have medical problems or physical disabilities, the largest group is composed simply of children of minority backgrounds. Because of socio-economic factors, these children, of different or unusual ethnic or racial groups, are greater in number than couples of their own group who apply to agencies to adopt or to become foster parents. These children, like all of our children, need the love and security of a permanent family. We have developed some approaches to reaching this goal for them, approaches which we are always trying to improve.

Preparing the Natural Parents

Our contact usually begins with the natural parent or parents prior to the baby's birth. The matter of what will happen if the baby is born with a medical problem usually comes up, and the parent is assured that the agency will help her to make some plan for the child. If the child is born so seriously handicapped that he cannot benefit from family living, he usually remains in the hospital or in a special boarding home until he can be transferred to an institution for the care of defective children. If the handicap is severe but the child can benefit from family living, he is placed in a foster home while he is under medical treatment and until an adoptive home can be found for him afterwards.

In such a case, even though it might take the agency some time to find a home, a surrender is taken if the parent wishes. If she is known to us on a private basis, we might ask her to apply to the public agency to have the child's cost of care underwritten. But a parent is asked to do this only if it would not be too destructive for her emotionally or if she were clearly eligible for public assistance. If a baby develops a handicap after a surrender has been signed, the agency does not re-involve the parent but takes total responsibility, which includes medical costs and costs involved in special boarding care or institutional care.

In working with parents of unusual racial or nationality admixture such as part-East Indian or part-Filipino, we tell the parent that it may take a few months to find the appropriate family for the baby. Often it takes less time because we have been trying to find a possible family for him even before his birth.

We find that the natural parents of Negro and Puerto Rican babies are usually aware that adoption homes are not readily available, and we have been helping them to understand that adoption may be very long in coming or only a remote possibility for their babies. We assure them that we will continue to provide for and plan for their babies in foster care and to work toward adoption in the best way possible. We encourage any mother who feels that she wants to and can make an

* Given at the CWLA Eastern Regional Conference, February 5, 1960, Philadelphia.

adequate plan to keep her child herself, whether that be in foster care, with relatives, or in her own home.

The Use of Foster Homes

We have been fortunate in having readily available a variety of good foster homes for all babies for whom it is difficult to find adoptive families. Every effort is made to place a baby in a family as soon after birth as possible (usually at five days of age), either in an adoptive home or in a foster home where he will not have to be moved except for adoption. This we hope will eliminate or minimize the effect of early deprivation and avoid the disturbances of development which John Bowlby describes as coming from a lack of close individual mothering or from separations and changes in early infancy.[1]

We try to avoid early changes in foster homes by choosing the right home in the beginning. Since we know only very little about the baby other than perhaps his background, his physical description or medical problem, we must understand fully the foster parents and their capacity to meet special needs. Then in the pre-placement interview with the foster parent related to a specific child, a further evaluation of the placement plan is made. After placement, our skills are used to continue to evaluate the total situation and to maintain this home for the child.

If the child has a medical problem we secure whatever is necessary as diagnosis or treatment; we engage the help of other disciplines—psychological, neurological, genetic, surgical, etc. This early diagnosis and treatment guides us in our selection of an appropriate adoptive family and later helps us in our interpretation of the problem to the adoptive family.

Catherine was an infant whose maternal grandfather had diabetes. We consulted our geneticist who explained that the baby would not necessarily tend to inherit this disease. Our medical doctors examined her and found no medical problem in the child. They also were encouraging about the great progress that has been made in medical control of this disease. Myra, another infant, was found five days after birth to have a congenital heart condition. She was followed closely at a cardiac clinic on an out-patient basis until the cardiologists determined the extent of the problem. Even though she would have to have surgery at five years of age, we were able to place her in adoption when she was seven months old.

We have been able in the past year to find adoptive homes for several babies who had harelips and cleft palates, placement being made only after the harelip or cleft palate was corrected. All these babies were placed before they were six months old. We are currently following closely little Jimmy who was born on January 1. He has a cataract on his left eye, and it will have to be determined whether and when this will be operable and what the course of treatment will be.

While these babies are in their boarding homes, they are getting a great deal of love and tenderness from their boarding mothers who personally take them to clinics and fully understand the problems. From a thorough knowledge of their total health picture, we gain the security to proceed and to convey this security later to adoptive parents. They, with an understanding of the babies' special needs, may receive much gratification from seeing these children grow and develop in response to their love and care.

"Screening In" Adoptive Applicants

How do we go about finding permanent families for these children? Our intake policy with prospective adoptive couples is one of screening in rather than screening out. In practice, this means more reliance on positive indications of ego strength and capacity for parenthood and less reliance on arbitrary factors such as age, length of marriage and the like to rule out some of the great numbers of couples inquiring about adoption possibilities. Whereas we place most of our children with couples under forty, couples married at least three years, couples not previously married, and couples who have done a certain amount of medical exploration of their infertility, we do not rely on any single one of these or on any other factors to "rule out" at the point of intake any couple wishing to explore adoption with our agency.

At the time of their first inquiry, we acquaint all white couples with the fact that there are so many more couples wishing to adopt than there are children needing place-

[1] John Bowlby, *Child Care and the Growth of Love*, Penguin Books Ltd., Baltimore, 1955.

ment that there will necessarily be many applicants whom we cannot help. Our selection of couples must be based on the needs of the children. This is spelled out in more detail at our weekly group meetings for adoptive applicants. Couples are then advised of the hard-to-place children whom we have under care or on referral. Some show an interest in the hard-to-place child during the discussion, mentioning similarities in their own families and asking specific questions. Any couple is free to have interviews after this, and this whole period is considered an exploratory process with no commitment on the part of the applicant or the agency.

Special staff members are used for the screening process, and they and certain administrative personnel form a committee which periodically selects from the large groups being seen the types of couples we will need for the children we anticipate placing in the months ahead. At this point, we are able to spot couples who might be a resource for the hard-to-place child. For example, one couple who ultimately adopted a child with a history of glaucoma were parents of teenagers. The wife, in her late thirties, had these children by her first husband who had since died. Another couple in their early forties, with a grown son of their own, wanted a little girl and were accepting of a baby with a slight cerebral palsy.

We know that in a given year we will have approximately twenty children of some unusual racial admixture—part-Chinese, part-Korean, or part-East or American Indian. We also know that in any given year we will be working toward placement of another twenty or thirty children with medical problems such as cleft palates, harelips, heart conditions and orthopedic problems. Our experience has proved to us that by having an open door to a great range of couples, many of whom might, by more specific criteria, be considered ineligible at first glance, we will be able to find some who have the capacity to encompass the more difficult to place child.

A Home for the Minority Group Child

For children of certain minority backgrounds, it is necessary for us continually to recruit families. For most Negro and Puerto Rican children, adoption is not a probability. Of the large numbers of Negro children in New York City who are available for adoption, adoptive families may be found for only a few. By concentrating exclusively on adoption, however, agencies sometimes have overlooked the other large percentage who need permanent foster homes.

Spence-Chapin has a conviction that the era of great specialization in social agencies has passed and that an agency has a responsibility to offer multiple services to its constituents. In 1958, Spence-Chapin added a long-term foster care service to its program in order to more fully plan for those children, predominantly of minority groups, for whom we cannot readily find adoptive homes. We are developing foster homes to rear them from birth or early infancy to maturity so that they may feel very much a part of the total family though they may not be so legally. Family- rather than child-centered casework service in these foster homes will build most of the securities that adoption provides. And hopefully the child will have to be transferred infrequently, if at all. We are extremely pleased also to report that many of these foster parents have already legally adopted their foster children, and that at the present time we are completing nine more legal adoptions which developed out of foster care.

We have found some suitable adoptive homes for children of minority groups through Adopt-A-Child clearance agency. This agency was organized some time ago in New York City to promote adoptions for children of minority backgrounds. In 1956, the Allocation Committee of Adopt-A-Child set up a clearance service between agencies to facilitate placements of minority children and to offer a wider selection of suitable combinations of children and homes. Most adoption agencies in New York City and in the Greater New York area joined in. While it was in operation, Spence-Chapin found some excellent homes for a small number of children of minority background through this service. Recently we have had some success in finding adoptive families for a few children by calling upon other adoption agencies individually for possible families which they might have for specific children.

By and large, however, our most successful resources for recruitment of families for these children have been our own adoptive families

and foster homes. The approach to recruitment through mass media has not been successful, largely, we feel, because of our inability to convey to large numbers of people that agencies do not now have rigid requirements for adoptive parents or ask large fees. However, when their friends, neighbors, and fellow workers tell them and show them, we find many more Negro families interested in adoption. We have asked our foster parents to refer their friends and relatives to us, whether they are interested in adopting a child or in serving as foster parents. Our foster parents are well informed about the agency's services, policies and procedures, receiving regular interpretation from their worker and from the entire staff at annual group meetings for foster parents. We have not specifically asked adoptive couples to refer interested people to the agency for adoption, but many of them have done so on their own.

The Placement of the Older Child

Our foster families are of tremendous help when an adoptive family has been found for an "older" child. In our experience, adoptive families for children three years of age or older are more difficult to find regardless of their race or ethnic background. When "older" children are being placed the utmost skill of the caseworker, together with the sensitivity and cooperation of the foster parents and the adoptive parents, is needed to minimize the traumatic effects of separation. We use the transitional method as suggested by Dr. Margaret Gerard.[2] The social worker must recognize the child's individual needs and the meaning of his reactions as well as those of the adoptive parents during the placement process. Our foster parents are helped to understand the process too and to accept the reactions of the new parents. Though the foster parents may be suffering tremendously over the loss of a child whom they have grown to love as their own, they are usually able to help a child move slowly from their home to the new home. This may take days or weeks until the new parents are well known to the child, and the child has begun to feel affection for them.

[2] Margaret Gerard and Rita Dukette, "Techniques for Preventing Separation Trauma in Child Placement," *American Journal of Orthopsychiatry*, January 1954.

For the older child, the visits with the new parents, or "showings" as we refer to them, take place in the foster home or in the adoptive home whenever the realistic factors permit. When placed, the child takes along to his new home some of the toys he cherishes and the new parents are given details of his daily living, all of which helps the child to have some of his old familiar things and ways in his new home. We have been able, in some situations where the children were pre-school agers, to have the foster parents visit the child shortly after placement in his new home. This is done only after it is felt that the child has gained security in the new home. If the child is placed with an adoptive family in another state, as some of ours are, visits with former foster parents are not very probable.

We have placed only a small number of children with adoptive families who live in other states as it requires so much more time for planning and for the placement process, but this does represent one more possible way of finding homes for hard-to-place children. The referring agency in the other state does the home study and supervises the child in the home after placement and until the legal adoption takes place.

In Summary

In order to locate adoptive families for children with medical problems or for children of unusual ethnic backgrounds and racial admixtures, we interview large numbers of couples in intake. In the selection of couples, we rely more on positive indications for parenthood than on arbitrary factors, including age and various others, which are sometimes used to exclude large numbers of couples.

The same intake policy is practiced in finding homes for the other hard-to-place children —Negro children and those of other minority backgrounds. In addition, however, because there are so many of these children needing homes, Spence-Chapin is doing the following:

Recruiting permanent foster homes (often referred by active foster parents) to accept infants and to rear them.

Enabling boarding parents to adopt a child who is in their home and to continue to board another child if they wish.

Calling upon other adoption agencies for possible adoptive families for appropriate children.

Widening our area of service to other states to be able to find more adoptive families for hard to place children.

Our philosophy for serving the hard-to-place child is basically a creative one. We try to think of what we can do for a child rather than of what we will be unable to do. Our aim is to place children with some permanent family, be it foster home or adoptive, where both child and family will have a better life for being together. We plan to look near and far for these families and to apply the concept of an open door policy with intake of couples, for it is through our own true acceptance of healthy differences in people that we will work toward more constructive placements of children.

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Conference Employment Service

A public employment service will again be available at the National Conference on Social Welfare (Minneapolis, Minn., May 14 to 19). It will be provided by the Minnesota Department of Employment Security in cooperation with the U. S. Employment Service. Experienced Employment Service interviewers will review job orders and interview applicants, and labor market information will be available. This service, which is made possible by the cooperation of the National Conference, the National Social Welfare Assembly, the Social Work Vocational Bureau and the U. S. Employment Service, is available only to those attending the conference.

All state employment service local offices have appropriate forms for advance registration and will help employers and applicants in preparing them.

Employers wishing to use the service should register vacancies at the nearest local office of the state employment service, asking that orders be forwarded to the conference if they have not been filled by April 28.

Social workers interested in positions should register at the nearest local employment service office. A brief resumé of education and experience, job and location preferences, and desired salary should be included in applications, which will be attached to the employment service form. Job applicants should ask to have their applications forwarded to the conference if they have not been satisfactorily placed by April 28.

Each employer or applicant must check in at the Employment Service Center immediately on arrival at the conference, so that his earlier local registration may be activated.

Registrations will be taken at the conference, but applicants and employers can be given more satisfactory service if they register in advance.

All orders and applications filed will be returned after the National Conference to the local employment service office, which will check on whether they have been filled. If they have not, the local office will continue to try to effect a satisfactory placement through its regular employment service. (State employment service local offices accept social work orders and applications on a year-round basis as a regular part of their service.)

Deadline for advance registration: April 28, 1961.

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POST-PLACEMENT SERVICE FOR ADOPTIVE FAMILIES

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An adoption agency examines its service to families after placement.

WHAT is the goal of an adoption agency between the time it places a child with a family and the time the adoption becomes legal?

As an adoption agency, we are in the business of "creating families." We want to find homes and loving parents for children who have already lost one set of parents. We want to bring together children and parents who will belong together. We believe that during the period between placement and legal adoption, the work of the agency is to provide casework skills to help facilitate the process of developing this sense of belonging.[1]

In studying adoptive applications we participate in a sharing process: the family tells us about themselves, their hopes and plans, what they wish in asking for a child, and we try to help them sort out any unreal, daydream material and to look carefully at what is involved for them. The agency also can bring to bear its breadth of experience to help parents make a decision that is meaningful and which commits them. Once the agency places a child, we have a commitment to help with any problems that arise if our help is needed. This period after placement is important because it may be the basis for, or the barrier to, successful long-range adjustment between the adoptive child and the members of the family. In this period of important new emotional experiences in the family's life, some of the normally expected early difficulties between parents and child may need attention, lest they become more serious problems.

Throughout the whole process our goal is to help adoptive parents by supporting their feelings of adequacy. The agency accepts philosophically and theoretically that our service during this period is to the new family being created. We must thus look critically at what we do and examine carefully what procedures, attitudes, and beliefs may get in the way.

Attitudes Expressed by Adoptive Mothers

How do adoptive parents feel about the agency's activities during the period between placement and legal adoption? An agency usually does not find out. Iowa Children's Home Society, however, had the unusual opportunity to learn what fifteen of our adoptive mothers thought about our post-placement supervision of their homes. The survey tended to confirm the idea that our post-placement work needed some changes. The information was gathered three years after the adoptions became legal in a study by an organization not connected with the Iowa Children's Home Society, so that the mothers were free to express their feelings about our agency.

The placements in this group of families were made in 1956. For about half it was a second-child placement, which meant that the families' contacts with the agency extended back to the early 1950's. All of the families had contact with the agency around 1955, a time when our ideas about post-placement service were just beginning to be studied and questioned. Since then there has been a major shift in our relationship to adoptive parents. We no longer use the term "supervision," but have substituted "post-placement service." However, the expressions of these mothers, four years after placement, point up our struggle at that time. Although fifteen is too small a number from which to draw definite conclusions, the responses of the mothers

[1] According to Iowa law, "No child may be adopted unless by special court order, until he has resided in the adoptive home for at least one year. During this year, the home is supervised by a worker from the placing agency, a representative from the county welfare department, or by some other person appointed by the court." Iowa Code, Sec. 600.2.

showed that our relationship after placement was often threatening to them rather than helpful.

Nine of the mothers talked about the reasons for which the agency came to visit. Three related the worker to both the parents and the child: "They want to see what kind of adjustment the child's making and what kind of an adjustment you're making." "They want to see how you're adjusting to each other."

The other six expected the worker to come for the child's benefit. One of them said:

"Their main concern is with the child, as it should be. They want to see her in her home surroundings—how she reacted to a visitor, how she played with her toys, how she conducted herself properly at the table. Their primary purpose was to see how well she was, if she was healthy, and if she was getting enough to eat."

On the subject of supervision as an experience, the fifteen mothers expressed attitudes ranging from "It was sheer pleasure," to "It was a relief when it was over." Among the fifteen was one mother who had been able to use the worker for help with her first adopted child, but could not use her with the second one. In relation to her first child she said: "I appreciated those visits. They offered suggestions. I felt they were friends," For her second child she said, "I didn't feel I needed them."

Seven of the mothers were able to use the worker during the period of supervision. Five of these used her as a friend more than as someone to whom to turn for help. Representative comments were:

"It was sheer pleasure. The social worker comes out and visits and all you have to do is sit and gloat over your child. It's kind of sad when its over. It's more of a social thing. You become attached to these people. It is like a friend."

"They should have been more in a position to help me than they were. They would have needed to have a psychiatrist on their staff and they just didn't have one. I made a good friend of my social worker. We just visited and visited."

Two mothers felt they could get some help from the worker. One said: "If you had any difficulty you know they'd help you—you are more at ease." The other said: "I had a feeling I couldn't *ask* anything that I really wanted to know. What she could help with, she did. The little boy was very jealous. She helped me there. She is trained to do that sort of thing . . . you might as well use her."

Three of the mothers accepted the visits as part of the procedure, with neither enthusiasm nor resentment, but with an implication that they might have been threatening to them:

"I didn't resent the visits. You'd sure hate to get to the end and find you're not suitable. If there was something they found they should tell you."

"I didn't think about the year too much. I was glad when the year was up but I didn't worry about it. I felt real close to her."

The study of the responses of the mothers made us even more aware of the insecurity of adoptive parents and made us question whether our presence in their homes added to this feeling. We wondered whether we had actually changed our concepts or only the words used. The mothers' statements resulted in our taking a good hard look at our practice in relation to the special attitudes which adoptive families may have and which agency staff members have, and recognizing the need to consider these if the agency is to be of help to adoptive families.

Special Problems of Adoptive Parents

Adoptive parents may be more insecure than other parents because of their inability to have a child. They may be prevented from acknowledging problems openly because of their strong need to prove their adequacy, not only to their supervising social worker but also to themselves. They may see the worker as representing just one more demand to be complied with, instead of recognizing her as a skilled person standing by at a time when the family may well need help.

The parents may feel that they are on "probation," which would produce a state of anxiety. They may wonder whether the agency is with the family, or with the child as opposed to the parents. They may harbor some fears that the agency will evaluate the situation and take the child away. Assisting adoptive parents during the post-placement period thus involves understanding and systematically developed methods.

The placement of a child brings about changes in the pattern of family life. The

degree of the adoptive couple's conformity to the beliefs and social rules of the larger community may determine the way in which they deal with their feelings about their adoptive child's characteristics, and the efforts they may exert in trying to influence his behavior. It may determine the amount of help they can accept or even seek from a professional worker.

Special Problems of the Agency

We gear our interviews to alleviating the pain for the applicants we reject, but there is also the possibility of developing insecurity in those whom we accept. By the process of choice, we may place upon those accepted an undue burden of having to live up to an unrealistic standard. Hence they may be reluctant to reveal problems lest they seem to fail us. Also, through the evaluation process, the adoptive parents may become more sensitive to their inadequacies, real or imagined, as they come seeking a child.

Within our agency there is still some talk about post-placement "supervision," although philosophically, this term has been discarded. Much of our discussion in interviews during this period conveys the idea in the minds of adoptive parents that our main interest is in the child—how he is doing, how the parents are handling him. The extent to which actual practice reflects current theory varies from worker to worker according to his individual convictions and his ability to apply new ideas and theory to practice.

The post-placement period may be a time in which to provide help in working through difficulties while clarifying them, if it is possible for the agency to make effective use of that time. Our emphasis during the period, in keeping with our goal, is family centered.

In order to help adoptive parents accept the services of the agency after placement, the worker must start with himself. He must be able to evaluate his own relationship to the parent figures. Is he looking for his ideal parent; is he unable to deny any parent? We may be evaluating couples in relation to our own standards and experiences rather than in relation to what is appropriate for them.

The worker creates the climate which will determine, in large part, the adoptive parent's acceptance of post-placement service. Here is the opportunity to show acceptance of the adoptive couple as people. Recognizing that continued anxiety will damage the ego-strength of the client, the worker's efforts should be toward reducing anxiety, which he may do by establishing early that he is on the same side of the fence as the adoptive couple and he wants to look at the situation with them. The adoptive worker has the opportunity to use the study process and post-placement period to build up self-confidence and encourage adoptive parents to handle their children with more spontaneity and naturalness.

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READERS' FORUM

Negro Adoptions

To the Editor:

We in Minnesota were much interested in the experience of Lake County, Indiana in its concentration of efforts to recruit adoptive homes for Negro children. This experience was ably described by Mrs. Mildred Hawkins in the December 1960 issue of CHILD WELFARE in the article "Negro Adoptions—Challenge Accepted."

It is encouraging to see additional communities making special efforts to crack the bottleneck in adoption—that is, the problem of lack of adoptive homes for children merely because of the color of skin. The Lake County experience is comparable to that of San Francisco's MARCH, of Los Angeles, of Chicago's "Negro Adoption Project," of New York's "Adopt-A-Child," of Washington D. C., and of other communities which have undertaken special projects.

For over two years a committee of adoption agencies, welfare councils and Urban Leagues has been preparing the way for a similar project to get under way in this state. Although the volume of Negro children in need of adoption is not as great in Minnesota as in most of the other communities which have had special projects, we, nevertheless, have an increasing imbalance of children as against po-

tential adoptive homes. In addition, Minnesota has a large group of children of American Indian ancestry for whom adoptive parents also must be recruited.

Unlike most of the other communities which have had special projects financed from private foundation funds, Minnesota plans to centralize its project within the State Department of Public Welfare. Funds for staffing are being requested in the Child Welfare Services budget from the Federal government. At the present time, a staff director is being sought under Civil Service to head the project. Cooperation of all adoption agencies, public and private, is anticipated. An advisory committee of lay citizens will be appointed by the Director of Child Welfare to work with the project. It is hoped that the program will soon be in operation.

We believe that the use of Federal child welfare funds in this area certainly falls within the intent of how such Federal funds can be of special aid to state programs. If, through a demonstration of pinpointed effort in recruiting, more children of minority racial background can be provided with adoptive homes, such a specialized attack on the problem may well become an ongoing part of a state's child welfare program.

CHARLES B. OLDS
Executive Secretary
Children's Home Society of Minnesota
St. Paul, Minn.

BOOK NOTES

Detention Practice, by Sherwood Norman. New York: National Probation and Parole Association (now the National Council on Crime and Delinquency), 1960. 221 pp., $2.50.

This is a valuable and informative compilation of the diverse practices in the detention of juvenile delinquents across the country. It takes into account that the circumstances of children's courts, ages of children, and physical facilities differ from state to state and county to county. Without pointing the finger of scorn nor giving accolades, the general tenor of this review is one to which communities should give serious attention. The emphasis is on short constructive periods of detention for the young in healthy surroundings, certainly not in jails. It recommends properly planned institutions yet places even greater emphasis on the quality, training and attitudes of staff, both professional and non-professional.

The fact that competent social workers are needed in this very delicate and important area of child welfare calls to mind the great shortage of such workers. Yet in every instance, the author indicates the inestimable value of either evaluation, diagnosis or treatment of children remanded by the juvenile courts. Surely this need of casework exists as well in the area of prevention. The premise is well taken in this volume that every effort should be made to keep the child in the home and the community, rather than in an institution of restriction. It is sad to note that wherever detention facilities are enlarged, they are filled at once. This is a difficult problem and one which weighs heavily on both large and small communities. However, with the improvement of physical plants, careful consideration should be given to the use of the buildings. They should not be the first but rather the last resort. This entails a careful review of cases, services, and potentials of child and family.

A manual of information such as this is a fund of knowledge for practitioners in welfare, for judges, and for students in the field of juvenile delinquency. It can go far in stimulating the improvement of conditions in detention shelters throughout the nation.

ETHEL H. WISE
President, Youth House
New York City

Public Welfare Services and Aid to Dependent Children. American Public Welfare Association, 1313 E. 16 St., Chicago, Ill. 10 pp., 35¢.

The recently issued policy statement on Aid to Dependent Children, prepared by the APWA Committee on Services for Children and Youth, is an extremely important and timely statement. The fact that the publication includes background and interpretation of the ADC program as well as the policy statement itself makes it particularly valuable. The statement should not only be read but should be discussed by legislative committees, boards and staffs of public and private agencies, planning bodies and funding groups as well as chapters

of the National Association of Social Workers and other groups concerned with social services to children and families.

The American Public Welfare Association statement is prepared both in light of the original purpose of ADC and in light of the twenty-five years of experience in administering this program in the various states of the Union. In essence, this statement presents a validation of the original purpose of the ADC program—"to encourage the care of dependent children in their own homes or in the homes of relatives. . . ." [1]

ADC is viewed in this statement both as a program of services to help maintain a child's own home and as a program providing economic assistance to families.

The purpose and philosophy of ADC as stated in the original Social Security Act and the subsequent revisions have been lost in the criticisms of the administration of the program. The APWA statement does not deny the validity of the criticisms of administration but cuts through this criticism to return to and restate the basic philosophy. In the past twenty-five years, other services and other financial assistance programs have been broadened so that they have impinged on the original group of children for whom ADC was established. However, there is no denying that ADC is still an essential program and can only be considered valid if the focus of its administration and services stems specifically from the principles presented in the APWA statement.

[1] Social Security Act, as amended through 1958, Title IV, Sec. 401.

The statement is particularly timely because legislation involving ADC is currently, or soon will be, considered by many of the fifty state legislatures. Therefore, boards and staffs of child welfare agencies should consider it their responsibility to bring the APWA statement to the attention of their legislators.

ZELMA FELTEN
Consultant, Child Welfare League of America

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Other New Publications

Chapel Hill Workshops, 1960. *Part 1,* Reports of the Workshops for Houseparents and Others Caring for Children in Institutions, 63 pages, $1.00; *Part 2,* Reports of the Workshops for Executives and Other Administrative Personnel Working in or with Children's Institutions, 71 pages, $1.00. School of Social Work, University of North Carolina, P.O. Box 69, Chapel Hill, N.C.

A Warm Friend for the Spirit, the history of the Family Service Association of Cleveland. Family Service Association, 1001 Huron Road, Cleveland, Ohio. $2.00, plus 35 cents postage and handling.

Handbook of Research Methods in Child Development, edited by Paul H. Mussen. John Wiley & Sons, Inc., New York, N.Y. 1,061 pages, $15.25.

Introduction to Social Welfare, *2nd edition,* Walter A. Friedlander. Prentice-Hall, Englewood Cliffs, N.J. 589 pages, $6.95.

Why Can't You Have A Baby? Alan F. Guttmacher, M.D. and Joan Gould. Public Affairs Pamphlets, 22 E. 38th St., New York 16, N.Y. Pamphlet No. 309, 20 pages, 25¢.

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CLASSIFIED PERSONNEL OPENINGS

Classified personnel advertisements are inserted at the rate of 15 cents per word; boxed ads $7.50 per inch; minimum insertion $3.00. Deadline for acceptance or cancellation of ads is sixth of month preceding month of publication. Ads listing box numbers or otherwise not identifying the agency are accepted only when accompanied by statement that person currently holding the job knows ad is being placed.

ADOPTION WORKER. Immediate opening for MSW with or without adoption experience. 35 hr. wk. Fee and auxiliaries financed. Salary commensurate with experience—minimum $5700. Maximum open. Beautiful San Joaquin Valley area. Contact William J. Freni, Director of Casework, Infant of Prague Adoption Service, 640 E. Franklin Ave., Fresno, Calif.

CHILD WELFARE SERVICES WORKERS for Southern California county. Opportunities in adoption included. Worker II ($5718–$6900) requires year's graduate study in social work and 2 years' experience or 2 years' graduate study. Worker I ($5142–$6192) requires 1 year's graduate study in social work. Paid vacation and sick leave, part-paid health insurance, liberal retirement benefits. County Personnel, Courthouse, San Bernardino, Calif.

CASEWORKERS—Several immediate openings for mature, flexible, competent persons. Challenging work situation. Required: MSW, with or without experience in child or family welfare agency. Salary related to applicant's qualifications. Fringe benefits. Write: The Adoption Institute, 1026 S. Spaulding Ave., Los Angeles 19, Calif.

CASEWORKER II or III for multiple-function child placement agency to be responsible for cottage placed and foster home placed children and their families. Psychiatric orientation, excellent supervision, MSW required. Retirement plan, Social Security and good personnel practices, health insurance, member CWLA. Salary: Caseworker II, $450–$563; Caseworker III, $503–$629. Vista Del Mar Child-Care Service, 3200 Motor Ave., Los Angeles 34, Calif.

LOS ANGELES—Openings for two caseworkers with graduate training in expanding family and child welfare agency—multiple services including marital counseling, unmarried parents, financial assistance, child placement in foster home care and group care, psychiatric consultation. Highly qualified supervision. Standard personnel practices. Opportunities for advancement. Salary, $5400–$7548 depending on training and experience. Write: Rev. William J. Barry, Assistant Director, Catholic Welfare Bureau, 1400 W. 9th St., Los Angeles 15, Calif.

CASEWORKER II or III (male preferred). In parent-child guidance service to families with troubled boys, aged 6 to 18, primarily youthful offenders. Psychiatric and psychological consultation available. MSW required. II—$5712–$7140; III—$6384–$7980, five step plan, salary commensurate with experience. Social Security, retirement, health insurance. Milton L. Goldberg, Executive Director, Jewish Big Brothers Association, 590 N. Vermont Ave., Room 366, Los Angeles 4, Calif.

CASEWORKER, MSW, experienced—Primarily to develop foster family care resources for disturbed children; small case load. Residential treatment setting. Salary range $5160–$7200; appointment salary dependent upon experience. Retirement plan, Social Security, good personnel practices, health insurance. Member CWLA. Contact Miss Lola Bowman, Director of Casework Services, Edgewood (San Francisco Protestant Orphanage), 1801 Vincente St., San Francisco 16, Calif.

SUPERVISOR OF CASEWORK: Family and Child Care Agency—Qualifications include professional education and experience in casework practice and supervision of qualified staff with psychiatric consultation. Agency functions: family casework, foster care of children, service to unwed parents and adoption. The responsibilities include directing casework services and student program with related community and administrative activities. Salary commensurate with good practice and current standards. Social Security and retirement benefits. For further details of position write: Miss Jane K. Dewell, District Secretary, The Diocesan Bureau of Social Service, 478 Orange St., New Haven 2, Conn.

PROGRAM DIRECTOR. Assist supervisor of cottage life in residential treatment facility for disturbed school-age children; supervise recreation and group workers; coordinate leisure-time activities with other departmental efforts; casework, psychiatry, music therapy, cottage living, food service, etc; recruit and direct volunteers; share "on-duty" coverage. Institution is one of our services—others are foster home, emergency foster care, adoption and counseling with unmarried mothers. Private, nonsectarian agency, member CWLA. Salary range $5400–$8100. Starting salary may be above minimum, depending on experience. May live off grounds. Prefer MSW in group work or casework with appreciation for group work methods. Oscar D. Weiner, Executive Director, Children's Center, 1400 Whitney Ave., Hamden 17, Conn.

SUPERVISOR of district office located in Norwalk, Conn. Staff of 3 fully-trained, experienced caseworkers. A private, statewide, multiple-service agency offering family service, foster home care and services to unmarried mothers in this office. Adoption placement and residential treatment service for emotionally disturbed children available within agency. Excellent personnel practices. Salary range $6000–$8100. Initial salary dependent on experience. Requirements: Master's degree in social work with at least 3 years' experience in supervision. Apply to C. Rollin Zane, Executive Director, Children's Services of Connecticut, 1680 Albany Ave., Hartford 5, Conn.

EXECUTIVE DIRECTOR CHILD CARE AGENCY SAN FRANCISCO. A challenging opportunity in progressive Jewish organization, maintaining both residential treatment center and foster home care. Trained staff, psychiatric consultation, intramural school, attractive plant. MSW required. Experience in child welfare work preferred. Salary is open and commensurate with qualifications for highly responsible position. Liberal benefits including pension and hospital plans. Write: Board of Trustees, Homewood Terrace, 11 Homewood Terrace, San Francisco 12, Calif.

CASEWORKER for small multiservice agency with diversified case load. MSW required. Within commuting distance of New York City. Starting salary $5300. Regular annual increments. Miss Mary C. Coughlin, Executive Secretary, Catholic Charities, 384 No. State St., Stamford, Conn.

CASEWORKERS in private, nonsectarian, statewide agency providing family counseling; boarding, day care and adoption home placements; comprehensive services to unmarried mothers; residential treatment for emotionally disturbed children; and protective services. Controlled case loads, excellent supervision, psychiatric consultation, student training program. MSW required. $4800–$7000. Initial salary based on qualifications. C. Rollin Zane, Executive Director, Children's Services of Connecticut, Inc., 1680 Albany Ave., Hartford 5, Conn.

CASEWORKERS—An opportunity to live and work on Florida's Gold Coast in a small multi-function child and family agency. Immediate opening for experienced adoption workers. Good personnel practices. Active board. Opportunity for advancement in an expanding program. Starting salary $5000–$7000 based on experience. Write: Father Bryan O. Walsh, Catholic Welfare Bureau, 395 N. W. First St., Miami 36, Fla.